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The Honourable MaryAnn Mihychuk

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● (1530)

[*English*]

The Chair (Hon. MaryAnn Mihychuk (Kildonan—St. Paul, Lib.)): I call the meeting to order.

We are here at the Standing Committee on Indigenous and Northern Affairs, looking at a study of long-term care on reserve. Today we have guests who are on video conference. Welcome, everybody.

Before we get started, we recognize that we're on the unceded territory of the Algonquin people here in Ottawa and under Parliament and thinking about truth and moving through a process of reconciliation.

Part of that is to look at the services that the federal government provides and at areas that we must address, so we are looking for your advice and wisdom in that endeavour.

The way it works is that you'll have an opportunity to present for up to 10 minutes. We'll go to the next presenter for up to 10 minutes, and after that we'll go to a round of questioning from the members here in Ottawa.

I understand we have with us two groups, the Loon River First Nation and the Association of Registered Nurses of British Columbia.

Does that seem logical?

Ms. Tania Dick (President, Association of Registered Nurses of British Columbia): Yes.

The Chair: I'm going to ask you to time yourselves. If not, just look once in a while and I'll try to indicate how many minutes you have left and when you need to wrap up.

First up is the Loon River First Nation. Go ahead.

Ms. Beverly Ward (Director, Health and Social Services, Loon River First Nation): Thank you, Madam Chair.

First of all, on behalf of our chief and council and our elders, home care clients, and community members, I'd like to say thank you for providing us the opportunity to do this presentation on the long-term care project that we've been working on.

I'll tell you a bit about our community. Loon River First Nation is a semi-isolated community with a population of approximately 650 people. We are located next to the hamlet of Red Earth Creek.

Loon River has a group of companies that are a separate entity comprising six companies. We are constantly moving forward toward becoming a self-sufficient nation. Loon River is part of the Kee Tas Kee Now Tribal Council, the KTC, which comprises five member nations. Loon River is centrally located within the KTC geographic area. The distance from each of the other four nations is approximately 45 minutes.

Loon River First Nation's overall goal is to construct and operate an accredited on-reserve continuing care facility that would meet the needs of KTC first nation members and be open to other surrounding communities. This facility would allow KTC members to receive care in a location convenient to their communities and their families, with services delivered in a culturally safe and respectful manner. This would most certainly add to the quality of life for those in need of continuing care.

It has been our vision to have a facility near home for our elderly clients and other home care clients who may need this service. We believe that having such a facility in our geographic area is absolutely critical to the health and well-being of our community members who are living with disabilities or chronic illnesses at any time in their lifespan. Access to this type of facility close to home will make a different to this clientele and their families. There are a number of elders in facilities as far away as 262 kilometres, in a German Mennonite community.

The process of our long-term care project started back in 2013. There was a call-out through the health services integration fund for communities to submit an expression of interest to develop a sustainable first nations continuing care model that would ensure delivery of a seamless continuum of health care and support services. Loon River seized the opportunity and submitted a letter of interest. Our plan was to have our own long-term care facility located on reserve or nearby, which would be open to KTC member nations and to other communities outside of KTC as well.

We realized that this was a kind of over-the-top project; however, we moved forward with it and were selected as one of the communities to start exploring this possibility with the health services integration fund. Since then, numerous attempts have been made to have government on board at all levels, meaning locally, provincially, and federally. Access to government funding is needed to make this dream a reality for our KTC member nations.

A feasibility study was completed, along with a business plan. A letter was sent to the previous government's health minister, Stephen Mandel, as well as the current Minister of Health, Sarah Hoffman. We've had no responses to these letters.

We have a steering committee comprising two members of chief and council; an HR and admin staff member; one elder; two caregivers; me, the KTC director of social services; and the director of health. We were seeking the province's support and to identify at least two people who could sit on this committee to assist us with this project. This never occurred.

In terms of our current state, Loon River First Nation is unique in that we have both health and social services under one department. We provide home and community care services that include nursing care and personal care provided by a health care aide.

We also have the assisted living program services from Indigenous Services Canada. We have access to the provincial seniors special needs assistance program as needed for various expenses the elders have, including home renovations. We have also accessed the residential access modification program; if the eligibility criteria are met, this program helps people with mobility challenges to modify their homes to be more accessible. Juggling numerous programs from various department sources and strict eligibility criteria is always a challenge.

● (1535)

Our priority is to have a first nations-staffed facility located close to home, which is what is needed to achieve seamless health care delivery for our continuing care clients. Being placed in an unfamiliar place is very stressful on our first nations clients. Not only is there a language barrier, but cultural sensitivity is also lacking at the urban facilities. All of this is a factor in the rapid deterioration of our first nations community members once they are placed in urban long-term care or assisted living facilities.

In terms of gaps, there is a significance to family closeness in first nations people, and distance is a factor when a client is placed off reserve, as family members are not able to visit. Other gaps are wait times, funding sources, and provincial and federal jurisdiction policies with respect to a facility being situated on reserve. In addition, many years ago, Aboriginal Affairs and Northern Development Canada placed a moratorium on new capital projects for continuing care. This has largely added to the ever-growing gap.

Thank you for your time. I'll pass this on to the director of health for KTC, Kirsten Sware.

● (1540)

Ms. Kirsten Sware (Director of Health, Kee Tas Kee Now Tribal Council, Loon River First Nation): Thank you for having us here today and for the ability to present to you.

I have just a few more minutes to add to Beverly's presentation. I'm from the tribal council. She's given you an overview of what the Loon River First Nation has been looking for in terms of long-term care on reserve. Five years of work has still netted nothing, so I think we need to look at the obstacles and opportunities that are in front of us, along with our realities.

I've had the opportunity to read some of the previous comments in presentations. While it's true that there are some facilities on reserve striving to meet the needs of the members, there is no designated capital fund available. What we desperately need is some supportive living and extended and comprehensive complex care facilities that can house our clients coming from the reserves. Part of our discussion in getting ready for today was that we need you to understand who goes into long-term care and why.

I also noted from some of the previous documentation that you were looking for statistics and data and were questioning whether that was out there and how you could get it. It's not formally out there, as you've probably discovered.

Going beyond that, I think, is looking at the numbers and why we have people who aren't going into care. I think it's because the care is not responsive to what we need and it's not located where we need it. We need it in the right place at the right time. We need it at the community level and we need it to be culturally relevant to how our communities, families, and extended families live and support each other. Unfortunately, the policies and programs are sometimes in conflict with that philosophy, that holistic view.

That's all I would like to add at this time. We prepared and sent a presentation. I know that it was sent late, and I apologize for that, but it may still give you additional information for your work.

The Chair: Yes, we do have your presentation. It's helpful.

We're now going to our next presenters, and then MPs will have a chance to ask you more detailed questions or to focus on a particular topic.

Now we're moving on to Tania Dick, who is representing the Association of Registered Nurses of B.C.

Welcome.

Ms. Tania Dick: Thanks for having me.

I was really excited to hear that this discussion was happening, that the question was on the floor. I know from the stories that were just heard from our previous presenters that this discussion has been going on for a long time. Trying to problem-solve issues for our elders at home as much as we can with the no-action piece of it has been the frustrating part over probably the last generations.

I'm a registered nurse, a nurse practitioner. I am the president of the B.C. nurses here in B.C., specifically to advocate for the indigenous health portfolio piece. I'm also on chief and council and on the board for my tribal council to continue that advocacy piece around health in our rural setting. I have done a lot of legwork in that area and there is a lot of frustration and a lot of lack of action in that area, so it was good to hear the stories of the people before me.

When I think about long-term care in our first nations communities, I instantly go to my nurse's lens. We work as nurses to keep people at home as long as possible as safely as possible. Quite often doing that means relying on a team in the community and in the acute care setting. We're fortunate enough in my rural community of Alert Bay, which is a small island with a population of about 1,500 literally split down the middle between off-reserve and on-reserve, to have a provincially funded hospital on reserve. I work in acute care. It has a full ER trauma room and acute care beds, as well as a 10-bed multi-level care area. That was really built with discussion with the community, with the Namgis First Nation. As it went, it fell into the province running those services. We weren't able to utilize those beds for our people. We had to put our people into the pool like everybody else in the province, so out of the 10 beds, I think at this moment we have three local people, which I think is one of the higher numbers I've had. I've been working there for the last six years.

Quite often we have to send our residents to a hospital somewhere else off reserve, quite often hundreds of kilometres away. Once we had to send someone to a completely different province until we could figure out some of the bedding issues and get them back. That's really difficult on the patient and the families, because as indigenous people, we're very person-oriented and we need to be with our families.

I'm a master's prepared nurse, a nurse practitioner. I was working originally in indigenous communities with primary health care. My mom, who is a residential school survivor, got really sick and it got to a point where the community health services and the acute.... She had to move out of the village into Alert Bay and I had to move to Alert Bay to be with her because she was falling through the cracks so much. As a result of that—there's nowhere to be a nurse practitioner in Alert Bay—I ended up having to lose my licence for it. The lack of services and the lack of space and the opportunity to try to keep her safe and well at home as long as possible affect me personally and professionally. They've had a significant impact on my family and on me as a professional.

The big thing I notice on the island where I work is the jurisdictional issue. The island is literally split in half. We do rounds every morning with our community health nurses and our physicians, and sometimes our mental health team comes over from another location. We talk every morning about care plans and people in the community and how we can best provide those services for them. The band-hired nurses are unable to provide services to our people who live off reserve. My mom happens to be one of them because, geographically, the church had come in, and there is a big lot of land right in the middle of our reserve that is church land, so she's technically not on reserve and she cannot access those services. That was a big gap for her where she fell through those cracks. It became unsafe for her at home and in the community. I had to come home and step in.

We tried to readjust things as well as we could. In all honesty, my heart goes out to the nurses. They try to bend the rules as much as they can, but that jurisdictional issue leaves opportunity for such unsafe environments for our elders and for our community in general, because they can't cross that jurisdictional line, and it's vice versa for the provincial community health nurses who provide services across the whole island.

● (1545)

However, they only come over once a week, quite often once every two weeks, and sometimes once a month. They literally have to take a ferry. They come over on the nine o'clock ferry. They have to leave on the three o'clock ferry. By the time they sit down and do rounds, they really have one or two hours to spend with those individuals when they're trying to keep them home and safe and well as long as possible, before they have to go into a long-term care issue.

The other big issue I see all the time at home is the respite issue. We work really, really hard with our communities to try to build capacity and support families as much as we can for people to stay home as long as they can and as safely as they can. However, it leads to caregiver burnout all the time. It's so difficult on the family members. There are no services or support systems in place for those individuals carrying that burden. We have no respite bed in our hospital. When an individual brings somebody in for respite for a week, three days, or five days if they have to go to a medical appointment or somewhere else, we end up having to send that person to another facility completely off the island, or down-island 100 kilometres away, where there is an official respite bed. That's difficult for both the patient and the family.

The big thing I notice with that transitional piece for our elders and people who need long-term care services is that the composition of nursing services and health interprofessionals does not fit the needs. I think the team before me touched on that a bit. The composition doesn't fit the needs of the people. For instance, the FNIH nursing program is kind of baby nurses, immunizations, a little bit of wound care, and this and that. However, they're not really built for that kind of long-term care and chronic disease management and the critical situations our people are in, which puts a lot of burden on them professionally.

When we talk about elders right now, we're talking about my mother and also my mother's mother, who is not alive now. My mother is a survivor of residential school. Those elders above her and that generation before her are the ones who had their children taken away. When we talk about the composition of care and care plans, whether it's in long-term care facilities, getting them into long-term care, or preventing them from going into long-term care, we don't touch on any of that. When the system is not set up for that huge mental health piece—I appreciate how, at the beginning, it was acknowledged that we're working towards reconciliation—that is massive. We have to define that within the health care system, because it's not working. Quite often, that generation and the generation before them....

I'm the first generation out of residential school. That intergenerational trauma exists. The general feeling overall that I have experienced in my practice is that individuals don't have trust. They have a lot of fear, and they absolutely have a difficult time accessing services or entering these facilities or institutions. It triggers them, I'm sure. They avoid them as much as they can, and then they get into a critical state in the community where they come in and we are actually having to try to resuscitate them and kind of revive them physically through their chronic disease issues and get them safe again.

I feel like we're in a cycle. We need to be approaching it from a multipronged perspective. RNBC, the association I work for right now, just did a breakdown of all the designations of nurses. Licensed practical nurses, registered psychiatric nurses, nurse practitioners, and registered nurses all have a scope to help contribute to this. When we look at the composition of FNIH, the provincial services, and the community health nurses, we see that the LPNs and the RPNs are completely underutilized or not utilized at all. When we're talking about reconciliation, residential school survivors, wellness, and mental health wellness, we're not even using our psychiatric nurses, who are built specifically for that. I think we have to really untangle the composition of the service providers, whether it's in-house in long-term care facilities, preventing individuals from going into them, or just maintaining them at home as long as we can.

I hope I'm okay for time.

● (1550)

The Chair: You're almost at the very end. You have 20 seconds.

Ms. Tania Dick: Okay. I'll just shut it off there.

The Chair: I think you caught the attention of the members of the committee, so I'm sure there will be questions.

Our first questioner is MP Mike Bossio.

Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.): Thank you, Madam Chair.

Thank you to all of you for being here with us today and for your testimony. It does add to the value of the witnesses we heard previously and expands upon that. It's the personal stories that resonate so much with all of us and that will help us to inform how we move forward with this report and this study.

One of the topics we haven't heard directly addressed yet in this study is the mental health of employees in LTC facilities and health care workers who are in the long-term care field. Specifically for nurses and workers in the LTC fields, how have you managed the issue of the mental health of your members in your association or workers within your communities?

I pose that to both groups.

Ms. Tania Dick: Literally just last week I came from my facility, where we have been trying to build capacity within the city for more local indigenous people working with the groups. The experience of loss we have with people who are in our facility is....

We just had this big fight in B.C. about the PTSD presumptive legislation in which nurses are not included. A whole bunch of staff had a big conversation about the impact and about how mental wellness and mental health are affected for those service providers. Regardless of whether you're a care aide, an LPN, a registered nurse, or an ambulance driver, those losses and that weight of....

We see them coming into our facility in a critical state. They avoid the facility as long as they possibly can, because quite often they just don't trust it. We're really working on that internally, because I don't see that support coming from the health authority provincially. In B. C. we're under the First Nations Health Authority. That isn't happening quite yet. I know it's on the table and there's a lot of conversation about it, but there's a lot of work to be done. I see turnover within our staff constantly from burnout and just not wanting to bear that load.

● (1555)

Mr. Mike Bossio: Please go ahead, Loon River.

Ms. Holly Best (Home Care Coordinator, Kee Tas Kee Now Tribal Council, Loon River First Nation): I was elected to speak to this, MP Mike Bossio.

I'm a community health home care nurse. I'm not with a long-term care facility, but we have the same issues in that we are doing one-to-one care and we can have our clients for 10 years and then we lose them. We do have psychologists in our facilities who are routinely there every week. That helps if we access them, but a lot of times we compartmentalize our loss when we lose our clients.

We deal with this individually and sometimes as a group, because in some communities there are only one or two people in the home care situation who do the visits and stuff, so we have a very small team. In some places there's only one nurse or one health care aide most of the time. We work as a team, and that's how we support each other, but we do go to the psychologist when we have a loss.

Mr. Mike Bossio: Actually, that was something I was going to add to my question. As we work toward reconciliation, how can we ensure that the long-term care system is working toward reconciliation, and what steps can we take toward better psychiatric care?

Tania, I think you mentioned this in your statement. How can we do a better job in that area?

Ms. Tania Dick: I think it's the composition of the teams we have. When we look at FNIHB or FNHA, the federal health providers for the communities, I think those systems have not changed enough to utilize the full scope of all nursing designations or other interprofessional individuals. I don't have the privilege or opportunity to see a psychologist when things hit the fan for us, and literally nine out of 10 people who walk through the door are related to me. That has a significant impact on my mental wellness and my mental health, because when I'm resuscitating and so on, it's difficult. There's huge burnout, huge turnover.

Mr. Mike Bossio: It's not just physical and the hours that you put in, but the emotional burnout as well, right? It's almost a PTSD-type situation because it is family members you're dealing with. You're in a crisis situation, both in the moment and afterwards, personally.

Ms. Tania Dick: Yes. One of the truth and reconciliation recommendations is for more indigenous nurses and increasing numbers and capacity of health providers. If we don't have a system set up to protect them from those experiences, we're setting them up for failure. We're setting them up to be hurt is what we're doing.

Mr. Mike Bossio: This partially feeds off from where this discussion started. Witnesses have told the committee that long-term care on reserve is about "empowering and enabling" indigenous people to develop new and holistic models of care by building institutional capacity that meets health standards and that incorporates traditional knowledge, healing, and medicine into western health care practices.

What types of supports need to be provided to ensure that indigenous communities have the capacity to design and deliver health services that incorporate indigenous knowledge, healing practices, and medicine, and in turn help deal with some of the mental health issues? I know that a lot of indigenous cultural healing practices specifically address the wellness piece of it.

The Chair: You have about 45 seconds.

Ms. Tania Dick: I'm going to give you one quick story. I've been advocating for my hospital to have traditional food in the long-term care facility. I just spoke with the national dietitians. They don't even allow us to bring in salmon, elk meat, or anything. You have to follow their policy. Our traditional foods are medicine for our people, and we're not allowed to utilize them. It drives us crazy.

● (1600)

Mr. Mike Bossio: Maybe, Loon River, you could give a quick comment as well on that.

Ms. Kirsten Sware: Sure. Thank you.

Bring post-secondary education close to home and integrate that within our facilities. We have to educate our own. They won't come from somewhere else.

The Chair: Okay.

Mr. Mike Bossio: Thank you all so much.

The Chair: The questioning now moves to MP Cathy McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you to both our presenters today. It was great to hear from you both. Since you're on video conference, I want to note that in our audience today in Ottawa, we have a whole class of nurses from British Columbia. It's good to see young nursing students here learning about both the challenges and the opportunities.

I'm going to start with Tania.

Ten years ago, I remember there was a situation in which there was a federal government nursing station beside a health authority station. The nurses for the indigenous communities were trained in immunization but the nurse for the health authority wasn't, and they were having someone from the health authority drive out to, I think, two babies who needed immunization. It was quite crazy that the jurisdictional barrier created just enormous costs, and frankly, a waste of money.

What you're telling me with your story about your mother is that this situation has not changed. I had hoped and I had been optimistic that with the First Nations Health Authority, there would be increased flexibility for some of those jurisdictional issues. Can you tell me whether there has been any improvement, and if there are still these huge jurisdictional issues in terms of what makes sense for a community? What would you recommend that we as a committee suggest to the government?

Ms. Tania Dick: I've been a nurse for 13 years now. My mother was a nurse as well. I think in the 13 years I've been practising, the jurisdictional issues have been there. They're not as bad as when I first started, and in defence of the First Nations Health Authority, that whole transformation in the delivery of services from the nursing perspective has not fully happened yet.

I know the conversation is still happening, and they're working really closely with the provincial health authorities. My whole cup is beyond half full around those changes occurring and pushing that change to happen, but yes, issues do still occur.

As for what I'd say you should recommend, I think all the other provinces and territories across the country don't have the same privilege we do as the First Nations Health Authority to go through that transformation stage.

As for FNIHB, the First Nations and Inuit Health Branch, I've never been a part of that organization federally, as a staff member or in discussion. I don't know how often they revisit that.

My interpretation of services coming in and being delivered to first nations communities is just "We're here, and we will do it this way." There was no discussion. There was no dialogue. There were no negotiations. There was no needs assessment. Historically, for generations, it has been this way. I think it's changed a little bit over my time, but I think it needs to change a lot more. If we want full empowerment and ownership of our health, we need to be able to have that conversation with whoever is delivering those services to us.

Mrs. Cathy McLeod: Would it be accurate to say that it's really the capacity to deal with the chain, as opposed to...? In the past there were federal government boundaries and rules. Is the reason that a nurse from the on-reserve community can't take care of your mother related to the change not having happened, although the barrier is not there anymore? Would that be accurate?

Ms. Tania Dick: I think that from a policy perspective the barrier is still there, but we as nurses are bending the rules. We are adjusting ourselves. We have a conversation at the table, "Oh, she's on reserve? Oh, she's off reserve?", and we come through another door. We just get creative with our practice to bypass those barriers. We look the other way.

Mrs. Cathy McLeod: Could the First Nations Health Authority make a decision? I guess maybe a better question is whether they would be able to make a decision that the money should follow the patient in terms of services.

Ms. Tania Dick: I'm hoping so. I'm definitely hoping that they can be a big part of this conversation as well, because I think the rest of the provinces and territories are looking to this rolling out and are not wanting to recreate the wheel but to get it right the first time. They want to help each other across the country to get this right and figure it out.

● (1605)

Mrs. Cathy McLeod: Thank you.

I would like to chat with our witnesses from Loon River for a minute.

Part of this motion is about palliative care and looking at the ability to provide palliative care either in facilities or at home. We heard from the department that their home care nursing services are provided from Monday to Friday from nine to five, which of course does not work for palliative care. Is that the reality where you live in terms of the support you can provide on evenings and weekends for people who choose to die at home?

Ms. Beverly Ward: Yes.

Ms. Kirsten Sware: That is the reality. Thanks for your question.

We are able to provide care from Monday to Friday from nine to five. I know that some of your previous witnesses indicated that there was a funding increase in budget 2017 specific to home care, palliative care, and perhaps occupational physiotherapy. By the time the amount allocated nationally gets down to the communities here, I can tell you that for the five communities and a population of 5,000 we've seen an augmentation to our budget of about $50,000. Let me tell you that when you get into the north, five hours from an urban centre, $50,000 spread across a big geographic area that has no specialized services doesn't get you very far.

We are still operating from Monday to Friday from nine to five. The palliative component is very heavily carried out by family, supported from Monday to Friday by our staff, who always go above and beyond their duties and answer their texts day and night, even on days off and during vacations, to support those families. That's our reality.

The Chair: Thank you.

The questioning now moves to MP Rachel Blaney.

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you, everybody, for being here.

I would like to start with the Loon River First Nation. I also represent a riding that has a lot of rural and remote communities, and I definitely know about the challenges of being far away and having to access services, and the limits there.

You mentioned that when there is a large area to serve, with many people spread over a large space, that bit of money doesn't spread across it. Can you chat for a second about the challenges for rural and remote communities when the dispensing of money happens, what the impact is, and how often—in my opinion—rural and remote communities are left behind?

Ms. Kirsten Sware: Thank you, MP Blaney. I'll speak briefly to it.

The money comes as it is allocated, and there are various formulas that do take into consideration a base and then some indices for remoteness and isolation. However, when you look at what $50,000 can do way out in the north in an isolated area compared to what $50,000 can do half an hour from the city of Edmonton, there's a lot of difference.

As Tania mentioned, you have to be very innovative in your work. Also, we just can't find the professionals who want to work in our northern and semi-isolated areas. It's not a location of choice, so there's only a very small group who are willing to work there.

Ms. Rachel Blaney: Thank you.

I'd like to go to you, Tania. It's good to see you.

Ms. Tania Dick: Hi, Rachel.

Ms. Rachel Blaney: I hope everything is wonderful back home.

One of the things we've heard from a couple of witnesses is that we need to look at Jordan's principle in a different way. When you're talking about the jurisdictional issues, I hear that loud and clear. One of the challenges for indigenous communities is the definition of "home is home", so if you live a few blocks away, when you want to get the support you need.... I we really need to be looking at this aspect, so I'm wondering if you could talk a bit about Jordan's principle, and how maybe focusing on service should be the key and figuring out who pays for it should happen afterwards.

Ms. Tania Dick: It's been an interesting process watching Jordan's principle roll out. Working within a system that really didn't understand, it has made our thought process change about that access piece. I think overall across society, when it comes to the disparities in indigenous health, an important lesson to learn in our practice is about the spirit or the foundation of Jordan's principle. Let's get rid of the boundaries, provide the care, and figure it out later, rather than having people turned away or ignored or not looked at.

I'm not sure what else to say, other than that it's had a profound impact on me within my practice to see other health professionals struggle with what Jordan's principle is and really break it down and fully understand the purpose if it.

More times than not, I hear other profession... say that it's just another handout, just another freebie for them, rather than really breaking that down and getting into the reconciliation mode when we're untangling it, really looking at it from a culturally safe perspective and understanding that we all deserve the care that everybody else gets across this board.

● (1610)

Ms. Rachel Blaney: I think your example really spoke to it. Especially in rural and remote communities, it isn't always just about indigenous people. It's about what services are available, who's allowed to access them, and why those barriers are there in the first place. I really appreciate your bringing that out.

I know your area fairly well, and I know that you work on the tribal council. One of the things we've heard a lot about is access to funding for long-term care facilities, specifically for indigenous communities. Could you talk about how big the need is, especially for those remote communities? What are the challenges of bringing multiple nations together to agree on where that location would be?

Ms. Tania Dick: It is a huge challenge, because in the tribal council I exist under, the reserves are geographically in very different places. As I think someone said, home is home. If I'm in Kingcome, that is home. If I'm in Alert Bay, it's a little bit different. If I'm in Port McNeill, it's way different. It would be difficult to come to terms with where the best access point would be to build a long-term care facility.

It is something that is so desperately needed, whether you look at it from the perspective of different levels of delivery of care or whether it's full-on long-term care. Assisted living is huge in our communities. There are so many people who are coming into our acute care setting and through our emergency department and taking up acute care beds. It is costing unbelievable amounts of money, and they could really be dealt with by having a safe environment like in an assisted-living facility, and then having another level of care, such as long-term care, when it's just not safe for them to be on their own or at home.

I'm an acute care nurse, an emergency nurse, and a lot of my time goes towards chronic disease management and issues that are costing 10 times more than they really should cost.

Ms. Rachel Blaney: For us today, this is the last half-hour of three and a half sessions, but I think this study should last so much longer. One of the members here in front of other witnesses put forward a motion to ask us to extend this study. I'm just wondering if you could talk to us about why this is so important and how it would benefit communities like yours if we looked at this situation in a more comprehensive way.

Ms. Tania Dick: I think it's a complex issue, particularly looking at it through that reconciliation lens, with the trauma that we carry as indigenous people in those generations right now, the residential school survivors. It is so desperately needed because from palliative care to chronic disease management to long-term care to acute care, we have less than adequate access to services, not only by choice but also since systems don't provide it. We have to look at it from both perspectives.

If we're not getting down to those layers and having that comprehensive discussion about it, we're not going to have the impact and the action that really are needed by our communities across the country. We have to pull back those layers much further. I think a huge discussion is so desperately needed if we are going to have an impact on the quality of life for this generation and the generations to follow.

Ms. Rachel Blaney: Tania, thank you so much for your time. I always appreciate it.

The Chair: Thank you.

Now questioning moves to MP Gary Anandasangaree.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): Thank you, Madam Chair, and thank you to the panel for joining us.

I'm going to start with Loon River. I'm wondering if the chief could speak to the current model of long-term care provision in Loon River and how it presently meets the needs of the community, or if it doesn't meet those needs.

Second, what are some of the challenges members of the community frequently face? What role is there for the federal government to fill in these gaps?

● (1615)

Ms. Beverly Ward: We don't have long-term care in the community. Obviously it's something we want to have one day. There's no money for capital, and that is what's needed in order to have it in our community.

Loon River is centrally located within the KTC member nations, as I said earlier. We have support from our KTC member nations to have a facility in our area. What we have right now is the continuing care that Health Canada provides us for home care, but as I said earlier, although we have nursing and health care aides, there is no long-term care.

The other thing I want to say is that once the capital funding is in place, what's needed is a continuum of care. We would need to look at that when we're looking at this project we're working on.

I don't know if this is the appropriate time, but I would like to thank MP Arnold Viersen for his letter of support a few months back in response to the letters we sent to the health ministers. Thank you, Arnold.

I hope that answers your question.

Mr. Gary Anandasangaree: Yes. Thank you.

To Loon River, I understand you currently have an extensive diabetes program that supports expectant mothers, youth, and the general community. How do you deliver those services currently? What's the delivery model?

Second, how is this programming developed, and how could this model be expanded to support such issues as long-term or palliative care?

Ms. Holly Best: I'm not sure. In the community, we do have programs for diabetes, maternal child health, and Canadian prenatal nutrition. We develop them using members from our communities. We educate them to build their capacity, so it will play into the prevention aspect.

However, in the case of long-term care, because we don't have any, our long-term care clients end up going off reserve. We have to go through a process with the province. We work as a team, but really we have nothing toward the long-term care of our clients, because once they're in long-term care, they're off reserve.

Mr. Gary Anandasangaree: Ms. Dick, can you advise us on whether your organization has developed any programs, such as sensitivity training or any other training modules, that will help nurses provide care to indigenous communities?

Ms. Tania Dick: Our association has not directly created those. There are a lot of modules throughout B.C. Most of the health authorities have mandated that nurses take the cultural competency training. A lot of the community reserves I've visited have the same sort of policies created and set in place. They purchase those services through the health authorities. They purchase provincial services because it's such a good program. The problem is that it's mandated through orientation—to have this job, you have to do this—but nobody is overseeing it. I went and talked to 12 nurses, and eight of them hadn't even looked at the program. Nobody is keeping track of it.

There are lot of programs out there. I've seen them across the other provinces and territories too.

Mr. Gary Anandasangaree: What would be the appropriate authority to monitor that? Would it be the nurses association? Would it be the registrar? Would it be...?

Ms. Tania Dick: I personally have always advocated for the regulatory body, the people who give us our licences. It's part of our licensing requirement, when we sign off as self-regulating, that we be culturally competent, but that's not enforced. In some cases it doesn't occur.

Mr. Gary Anandasangaree: Of the programs you have currently, do you know if any of them were co-developed with first nations communities?

Ms. Tania Dick: Yes. All of them were. They have done really well.

In terms of programs, I think Loon River talked about how they create their diabetic program from their community needs and get that information from them. I see that more and more as I travel around.

When programs came in and told you "This is what we're doing, and this is how we're doing it for you", it never worked. People didn't show up for their appointments.

● (1620)

Mr. Gary Anandasangaree: One of the things we've heard a number of times in other studies we've undertaken—and we're certainly hearing it again in this study—is the major challenges in recruiting and retaining health care professionals, particularly nurses, who are from indigenous backgrounds. Can you give us a sense of maybe the top three things we need to do to improve that and to support individuals who want to go into nursing?

Ms. Tania Dick: For the most part, what I've heard across the province is that wage parity is huge. Band-hired nurses are paid significantly less than a unionized nurse who works within the health authorities, or a provincial nurse—up to 20% less, sometimes 30%.

Also, on job safety, quite often these are fly-in communities and quite often you're the only nurse there. There's no one to bounce things off; you're working within your own specific scope of practice, and quite often nurses working in indigenous communities don't get the proper training for outpost nursing, so to speak. They have their immunization certification and they have whatever under the policies, but they get these emergencies that they have to answer to and can't really say no to, and it just doesn't fit. We're not—

The Chair: Thank you.

The questioning now moves to MP Arnold Viersen.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you, Madam Chair, and welcome to our guests, particularly those from Loon River. I know that community well.

Most of my questions will be directed the Loon River folks. I participated in the Celebration Days event last summer. One of the things that struck me was the significant respect that the community has for its elders. I saw the place of honour that they were given at the dinner table and how the entire community seemed to rally around them.

I was wondering about the long-term care. You note that there's only one member in long-term care, I assume off reserve. How does the community take care of its elders currently? What does the culture around that look like? I know that off reserve, typically, children most often take care of their elderly parents until they're moved into a seniors facility. How does that look on reserve? Is it the children, or is it an entire community involvement? Is there a particular grandmother that takes care of the old folks? How does all of that work?

Could we get a picture of how it works, particularly in Loon River, but maybe even more broadly in the whole Kee Tas Kee Now region?

Ms. Beverly Ward: Thank you, MP Arnold. It's nice to see you.

Mr. Arnold Viersen: It's good to see you again.

Ms. Beverly Ward: It takes a community, just like for children it takes a community. We appreciate our elders very much. They are a priority in our community, along with our children. It was good to see you at our Celebration Days.

I would like to bring up our assisted living program here with regard to your question, because a lot of the family members do take care of their own. I took my mom out of long-term care last summer, in July, and she's home with me. I'm also an LPN. I look after her. At the same time, I'm here at work. I pay someone to keep my mom so I can keep my job.

A lot of the families are looking after their own elders—their mom, their dad, and their *kokum* and *nimosom*, their grandma and grandpa—but under the assisted living policy as it reads now, we can't pay for family to look after their own. It's kind of not fair, because the family members can't work. Some of them have to resign from their jobs to look after their elders. It's really not fair with that barrier being there to prevent us from compensating the families. Yes, it is their family, but at the same time, they possibly have to go onto social assistance. Some of them really don't want to go that route, but sometimes they have no choice because the assisted living program is so limited in funding. Also, the eligibility criteria to get help there is limited.

It just doesn't work. It's not working for us right now, so the band has a band-funded program to accommodate that need for the people to look after their own. It's funded by the band. We don't get help from anywhere for that. That's what we have to do to meet the needs of our elders right now.

● (1625)

Mr. Arnold Viersen: I know that Loon River is located right next door to Red Earth Creek there, and there are a number of seniors who live in Red Earth Creek who will be looking for elder care in the near future as well. Is there any opportunity to collaborate with the local community?

Ms. Beverly Ward: There is that opportunity, and when we did the feasibility study, we did have that in there also, that facility that we're dreaming of right now that we want to become reality. It does include not only KTC member nations but also the hamlet of Red Earth and other surrounding communities north of us. We were open to that, and the feasibility study we had done did show that it would be better to have an open facility versus just KTC member nations.

Yes, we do work with Red Earth, and we also invite them to the services we have, which they can access in the health centre, such as seeing a physician. They come here to see the physician weekly. We do communicate with them and we work with them, even now. We go as far as sharing activities with them, like a Father's Day activity. We invite them and include them in our activities, and they do the same for us.

The Chair: Very good.

Questioning now moves to MP Danny Vandal.

Mr. Dan Vandal (Saint Boniface—Saint Vital, Lib.): Thank you.

First of all, I thank the presenters for their presentations. They're very, very good.

My first question will go to Loon River First Nation.

According to your presentation, a health centre was opened in 2000. I want to ask about the financing of the health centre and how it's divided up among the jurisdictions for the different services that you provide. Can somebody give me a basic overview of that?

Ms. Beverly Ward: The funding comes from FNIHB, First Nations and Inuit Health Branch, for our health programs. That includes nursing and all of our other programs like home care, public health, and all that.

Ms. Kirsten Sware: It's 100% funded and operated by the federal government.

Mr. Dan Vandal: It's 100%—both the capital and the operating funding?

Ms. Kirsten Sware: Yes.

Mr. Dan Vandal: If you were to make a suggestion for improved federal government services, what would it be?

Ms. Beverly Ward: I think that brings us back to the study that you guys are conducting right now with continuing care on reserve, because our ultimate goal is to one day have that facility here. It would be a service to all our....

Mr. Dan Vandal: That's the longer-term care?

Ms. Kirsten Sware: Yes, and I think I would echo the sentiments that have been shared today that you can't look at long-term care in isolation. It is a continuum of care. The long-term care is one piece of that, and the more effort we can put in on the front end, the less we'll need long-term care.

Mr. Dan Vandal: Prevention is key.

The Chair: Thank you.

Ms. Holly Best: The other thing might be that we could extend our home care and supportive services so that we offer more than Monday to Friday, nine to five.

Mr. Dan Vandal: Thank you very much.

The Chair: When you need care, it's not nine to five during the week, is it?

Thank you so much for participating. We've run out of time. Thank you for answering our questions, providing greater insight. *Meegwetch, merci.*

There's going to a short recess and then we're going to come back in camera to deal with committee business.

[*Proceedings continue in camera*]

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